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CHRONICLE OF THE WORLD HEALTH ORGANIZATION

CONTENTS

	Page
WHO in the Eastern Mediterranean Region	67
Anti-Venereal-Disease Commission for Rhine River area	72
New international standards	73
WHO congenital heart disease teams	78
First seminar for European sanitary engineers	81
An important study on maternal care and mental health	83
Insecticides and public health	85

Notes and News

Health demonstration area to be established in El Salvador	90
Malaria course in Lisbon	91
Malaria control in Indonesia	91
Antimalaria campaign in Thailand	91
Saudi Arabia to receive WHO assistance	92
Meeting on Draft International Sanitary Regulations	92
World Health Day	92
New ratifications of Constitution	92

RECENT AND FORTHCOMING MEETINGS

1950

2-9 November	WHO Expert Committee on International Epidemiology and Quarantine, Legal Subcommittee, third session, Geneva
6-7 November	WHO Expert Committee on the Unification of Pharmacopoeias, Subcommittee on Non-Proprietary Names, first session, Geneva
6-11 November	WHO Expert Committee on Biological Standardization, fourth session, Geneva
6-13 November	FAO/WHO Expert Panel on Brucellosis, first session, Washington
27 November-9 December	Commission for Technical Co-operation in Africa, WHO Malaria Conference in Equatorial Africa, Kampala, Uganda
11-12 December	Preparatory Working Group on a Public-Health Administration Seminar, Geneva
11-16 December	WHO Expert Committee on Malaria, fourth session, Kampala, Uganda
11-16 December	WHO Expert Committee on Mental Health, Subcommittee on Alcoholism, first session, Geneva
11-16 December	Joint WHO/FAO Expert Group on Zoonoses, first session, Geneva

1951

8-30 January	WHO Executive Board : Standing Committee on Administration and Finance, Geneva
22 January-5 February	WHO Executive Board, seventh session, Geneva
30 January	Léon Bernard Foundation Committee, Geneva
9 April-5 May	WHO Special Committee to consider the Draft International Sanitary Regulations prepared by the Expert Committee on International Epidemiology and Quarantine, Geneva
10-17 April	Joint FAO/WHO Expert Committee on Nutrition, second session, Rome
19-28 April	WHO Expert Committee on the Unification of Pharmacopoeias, eighth session, Geneva
30 April-1 May	WHO Expert Committee on the Unification of Pharmacopoeias, Subcommittee on Non-Proprietary Names, second session
May	WHO Expert Committee on International Epidemiology and Quarantine, Legal Subcommittee, fourth session, Geneva
7 May	Fourth World Health Assembly, Geneva
28-30 May	WHO Consultative Committee for Europe, first session, Geneva
31 May	Joint Committee on Health Policy, UNICEF/WHO, fifth session, Geneva
4-16 June	WHO Executive Board, eighth session, Geneva

WHO IN THE EASTERN MEDITERRANEAN REGION

WHO's Eastern Mediterranean Region comprises countries in two continents—Africa and Asia—with the exception of Turkey, part of whose territory is in Europe. These countries, though presenting wide diversity in many respects, possess a certain homogeneity with regard to health conditions. Countries in Africa which are included in the region are the Anglo-Egyptian Sudan, Egypt, Eritrea, Ethiopia, Libya, Somalia, and British and French Somaliland ; in Asia there are Aden, Cyprus, the Hashemite Kingdom of the Jordan, Iran, Iraq, Lebanon, Pakistan, Saudi Arabia, Syria, and Turkey.

Of the 182 million inhabitants of the region, 46 million belong to Africa and 136 million to Asia. Pakistan, which is not, geographically speaking, a proper Eastern Mediterranean Country, has 73 million inhabitants. Population problems in the region are conditioned mainly by two factors : (1) an unusually high birth-rate, and (2) a minimum of fertile land to meet the needs of the people. The area is largely rural, 90% of the inhabitants depending on agriculture which centres about a few rivers and scarce ground water. This gives rise to an incredible density of population in some countries, with consequent effects on health conditions. In Egypt, for example, the density of population is 550 per km², increasing in some areas of the delta to 2,000.

Regional Organization and Health Policies

WHO's activities in the Eastern Mediterranean Region began with the Eastern Mediterranean Conference, held in Cairo in February 1949.[1] The Regional Office was established in July of the same year at Alexandria, under the direction of Sir Aly Shousha, Pasha. A second meeting of the Conference, which had by then become the Regional Committee for the Eastern Mediterranean, was held in Geneva in October 1949 ;[2] the most recent session took place in Istanbul in September 1950.[3]

Much of the work of these first two years has been of an exploratory nature, as was essential ; and a very important quantity of information, documentary and otherwise, has been accumulated. With the exception of Somalia, every part of the region has been visited—many countries on more than one occasion—for lengths of time varying from a few days to a month. The importance of establishing personal relations between the countries of the region and the regional office by means of direct contact cannot be overrated and, in fact, can well count as the first major project undertaken.

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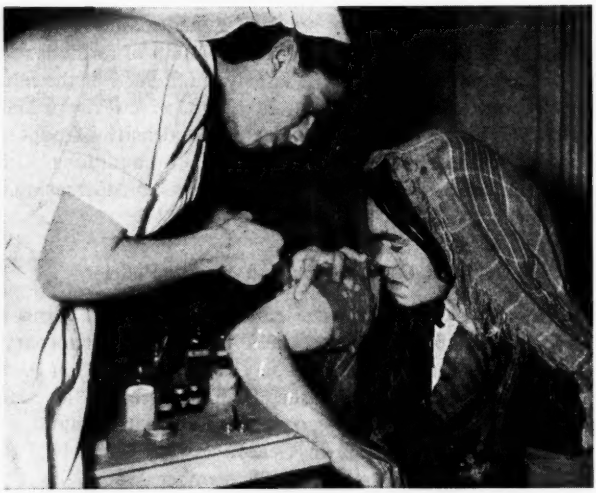
[1] *Chron. World Hlth Org.* 1949, 3, 48
[2] *Chron. World Hlth Org.* 1949, 3, 275
[3] *Chron. World Hlth Org.* 1950, 4, 374

Preliminary surveys have revealed certain facts about the Eastern Mediterranean Region. The first is that there is in this region a great appreciation of better national health as an asset of considerable importance from the economic standpoint, which makes governments tend more and more to assume responsibility for both the preventive and curative aspects of the health of their people. This is in contrast to the practices of certain western countries, but it obtains as an almost universal principle in the Eastern Mediterranean Region.

However, there is in the region very little in the way of tradition, beyond the universal principle of charity, to guide governments in their health

FIG. 1. EASTERN MEDITERRANEAN REGION - I



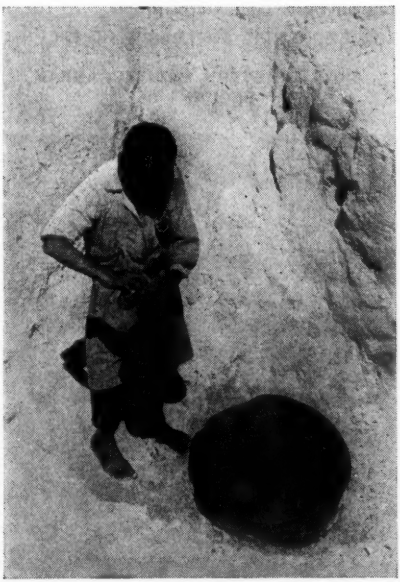
A syphilitic pregnant woman receives penicillin treatment as part of a WHO anti-venereal-disease campaign

policies. Independence and responsibility are relatively new phases in the history of many of the countries, which have had to create philosophies for themselves in their adaptation to modern concepts of progress. This in itself may not be a disadvantage, since it gives them an opportunity to adopt the best the world can offer without having to demolish too many time-honoured practices and institutions. On the other hand, customs and practices which have been inherited from earlier forms of government and administration, and which are not always in the best interests of the country, are sometimes exceedingly difficult to replace. Two striking

examples of this are the notions, now being seriously questioned, that (1) the public health of a country can be entrusted to persons who, because of their meagre salaries, must also work privately in order to live decently, and (2) public-health work does not require special training and experience. The latter notion has been forced upon certain countries by circumstances but is gradually being changed.

WHO has devoted much effort to exposing and attacking such misconceptions in public-health service wherever they have been found. WHO, and its Eastern Mediterranean Regional Office, have made considerable progress in establishing the principle that the health of the peoples of the region is not just a national affair but is closely interwoven with the health of those in other countries of the region, and consequently with the health of peoples all over the world. It is beginning to be understood that steady improvement of the people's health has a direct relationship with similar evolutionary processes throughout the world. An example of the co-operative spirit within the region was given at the second meeting of the regional committee when, after assessing local resources in terms of scientific institutes, medical and nursing schools, laboratories and hospitals, the various countries offered to share their facilities, however limited, with their neighbours : Pakistan offered its Malaria Institute at Karachi to train malariologists ; Turkey, its nursing schools ; Egypt, its laboratories and vaccine-producing facilities ; Israel, a research station for malaria problems ; Lebanon, its medical schools, etc. To allow full use of the experience and facilities available in the region, and to broaden the experience of local medical personnel, negotiations were undertaken to permit a wide intra-regional exchange of doctors, scientists, and other specialists. WHO gave additional aid by granting fellowships for study in countries both within and outside the region.

FIG 2. EASTERN MEDITERRANEAN REGION - II



Water supply has been one of the chief problems in the refugee camps in the Eastern Mediterranean Region. Here is one of the more primitive arrangements, a shallow water-hole dug on a beach some 30 or 40 feet from the sea.

It is recognized throughout the region that the amelioration of the health of the various peoples can best be accomplished by means of a regional health policy, and that the WHO Regional Office is the agency for co-ordinating national aspects of such a policy.

Health Conditions

Through the media of surveys and reports, the health needs of the region have been determined. In the Middle East, environmental factors are responsible for many of the major public-health problems. The climate, together with periodic floods, contributes to the maintenance and multiplication of insect vectors of disease ; lack of the most fundamental sanitation encourages cholera, amoebiasis, salmonellosis, enteric fevers, and various parasitic diseases ; artificial water sources—canals, irrigation ditches, unprotected wells, etc.—provide breeding-places for the vectors of bilharziasis and other diseases. Social and economic conditions favour the development and transmission of infectious diseases such as tuberculosis, bejel, smallpox, and cerebrospinal meningitis. Among the endemic diseases with which the WHO programme for the Eastern Mediterranean is most concerned are trachoma, bilharziasis, leishmaniasis, and malaria. Trachoma is especially prevalent in Egypt, Iran, Pakistan, and Turkey. In Egypt, for example, the number of cases of trachoma in patients attending the ophthalmic hospitals ranges from 79% to 89%, and the annual percentage of active infective stages among poor people varies between 30% and 73%. Bilharziasis is believed to afflict about 50% of the total population of Egypt ; its incidence is also significant in Iraq, certain areas of Israel, and Syria. Leishmaniasis is a very common disease in some countries of the region, but reliable and

FIG 3. EASTERN MEDITERRANEAN REGION - III

In contrast to the water-supply "system" shown in fig. 2 is this pipe-line system which was installed with the help of WHO sanitary engineers. The spring-operated taps are considered fun to work and were necessary because of the refugees' unfamiliarity with the normal turning tap, which they left running, thereby wasting much of the precious water.

complete data on its prevalence are not available. Malaria is one of the most serious health problems of the region, particularly because of its relation to the agricultural economy.

Regional Activities

Field work in the Eastern Mediterranean Region has been undertaken, or is about to be initiated, in several countries : malaria control in Iran [4] and Pakistan,[5] tuberculosis control in Egypt,[6] Pakistan,[7] and Turkey,[8] and treponematosis control in Egypt and Iraq.[9]

Studies by experts have been made on a number of health problems in various countries :

Subject of investigation	*Number of countries*
Public-health administration	11
Tuberculosis	5
Venereal diseases	2
Maternal and child health	3
Nutrition	2
Malaria	6
Miscellaneous	12

A fellowship programme has been developed with emphasis on public-health administration and environmental sanitation. By the end of 1950, 32 out of an allotted 78 fellowships had been awarded, and arrangements were being made for 21 additional ones. Of those already granted, six were in public-health administration and four in sanitary engineering. Ethiopia, which has neither medical nor nursing schools, was awarded four long-term fellowships for basic medical studies and six for nursing training.

The Regional Office for the Eastern Mediterranean maintains an epidemiological intelligence service inherited from the Pan-Arab Sanitary Bureau. It has instituted a public information service which broadcasts and issues press releases and publications in English, French, and Arabic.

Co-operation with Other Agencies

Co-operation with other international agencies assumes great importance in WHO's Eastern Mediterranean activities and will probably increase under the United Nations Technical Assistance Programme. With FAO, a nutrition training course has been conducted in Cairo, and plans are being made for a rural health programme in Lebanon and for a project to increase

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[4] *Chron. World Hlth Org.* 1950, **4**, 125 ; 1951, **5**, 28
[5] *Chron. World Hlth Org.* 1949, **3**, 135 ; 1950, **4**, 153, 193 ; 1951, **5**, 26
[6] *Chron. World Hlth Org.* 1950, **4**, 192
[7] *Chron. World Hlth Org.* 1950, **4**, 153
[8] *Chron. World Hlth Org.* 1950, **4**, 63, 154 ; 1951, **5**, 60
[9] *Chron. World Hlth Org.* 1950, **4**, 354

food production and to improve standards of health in Syria. UNICEF has been, or will be, a partner in numerous campaigns relative to maternal and child health, venereal diseases, and tuberculosis ; it has also contributed much to the fellowship programme. A joint project with UNESCO on fundamental and health education is envisaged under the Technical Assistance Programme.

An outstanding example of international co-operation in the region has been in the relief activities to aid the Arab refugees from Palestine. Since early in 1949 WHO has had a part in this programme.[10] The Regional Office has supplied medical (2), engineering (11), and health education (1) staff for these activities. WHO personnel have worked side by side with UNICEF, the United Nations Relief for Palestine Refugees (UNRPR), its successor—the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWAPRNE), and various agencies such as the American Red Cross, the American Friends Service Committee, the League of Red Cross Societies, and the International Tuberculosis Campaign. These and other groups, with financial assistance from various governments as well as international and philanthropic agencies, have pooled their efforts to improve the health, nutrition, and sanitation conditions in the refugee camps in the Near East, and their achievements have proved the efficacy of international co-operation.

[10] *Chron. World Hlth Org.* 1949, 3, 21, 67 ; 1951, 5, 27

ANTI-VENEREAL-DISEASE COMMISSION FOR RHINE RIVER AREA

The International Anti-Venereal-Disease Commission of the Rhine, the establishment of which has been under consideration for some time,[1] became a reality when the Executive Board, at its seventh session, passed a resolution authorizing its creation. The Commission, acting within the framework of WHO policies and in accordance with the terms of the Brussels Agreement of 1924, will, with the consent of the governments concerned :

(1) initiate the co-ordination of anti-venereal-disease services in Belgium, France, Germany, the Netherlands, and Switzerland with a view to strengthening the fight against venereal disease among Rhine River boatmen ;

[1] *Chron. World Hlth Org.* 1949, 3, 117

(2) initiate the establishment of diagnostic and treatment centres in the principal river ports which do not as yet possess dispensaries or specialized consultation services ;

(3) participate in the application of principles approved by the World Health Assembly to assure the functioning of venereal-disease services. These services will include, in particular, (*a*) free medical examination, treatment, and hospitalization when necessary, for foreigners as well as nationals ; (*b*) distribution to patients of an individual treatment-record card free of charge ; (*c*) international tracing of infectious contacts through exchange of epidemiological information, by direct communication between the medical authorities concerned where appropriate ; (*d*) development or creation of social services, preferably specialized, so that epidemiological action can be taken and social assistance be given to patients ; (*e*) distribution of an international booklet listing treatment centres, their addresses, and their consultation hours.

The Commission will meet once a year, and a full report on its activities will be submitted to the Executive Board annually. Two secretariats are to be established, an administrative office at Strasbourg, and a medico-social centre at Rotterdam.

This is the first inter-governmental commission of its kind to be established by WHO, and it may serve as a model for similar inter-governmental groups—in particular for an anti-venereal-disease commission which is being considered by the countries bordering the Baltic Sea.[2]

[2] See article by T. Putkonen concerning gonorrhoea among merchant seamen in Finland, to be published in a forthcoming number of the *Bulletin of the World Health Organization.*

NEW INTERNATIONAL STANDARDS

New methods of treatment using hormones, antibiotics, enzymes, and vaccines have made great strides throughout the world. A large number of substances, biological in origin, which cannot yet be defined by their physical or chemical properties alone are now in everyday use. It is urgent that international standards or reference preparations be established with respect to which the potency of the drugs in question, prepared in different countries, can be determined.

These drugs include : adrenocorticotrophic hormone (ACTH), several antibiotics, a number of substances which will appear in volume II of the *Pharmacopoea Internationalis*, and preparations such as cardiolipin and lecithin, used as an antigen in the serodiagnosis of syphilis.

In *World Health Organization : Technical Report Series*, No. 36, several new standards are defined by the Expert Committee on Biological Standard-

ization, which held its fourth session in Geneva from 6 to 11 November 1950.[1] During this session, arrangements were made for establishing a certain number of other standards and reference preparations. The replacement of standards of which the stocks are nearly exhausted was also arranged. A number of questions, relating in particular to various toxoids and vaccines including BCG, were discussed.

New Standards

Adrenocorticotrophic hormone (ACTH)

The unit of potency recommended by the committee as an international unit is the activity contained in 1 mg of the international standard preparation. The size of this unit was chosen to suit the convenience of the clinician.

Streptomycin

The international standard for streptomycin will be a streptomycin sulfate preparation. The potency of 1 mg of this preparation corresponds to that of 780 international units or microgram-equivalents. The sulfate was preferred to the double salt formed by streptomycin hydrochloride and calcium chloride, since it is homogeneous and easy to handle, being less hygroscopic.

Blood groups

A standard for anti-A and anti-B agglutinating sera was determined by combining the results obtained by eleven laboratories in ten different countries. The unit of agglutinating power of anti-A serum is the activity contained in 0.3465 mg of the standard preparation, and that of anti-B serum the activity contained in 0.3520 mg of the standard preparation.[2]

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[1] The following took part in this session :

Dr. J. Bretey, Chef de la Division de la Tuberculose, Institut Pasteur, Paris, France
Professeur E. Grasset, Directeur de l'Institut d'Hygiène, Geneva, Switzerland (*Rapporteur*)
Dr. O. Maaløe, Chief, Department of Biological Standardization, Statens Seruminstitut, Copenhagen, Denmark
Dr. A. A. Miles, Director, Department of Biological Standards, National Institute for Medical Research (Medical Research Council), London, United Kingdom (*Chairman*)
Dr. J. Ørskov, Director, Statens Seruminstitut, Copenhagen, Denmark (*Vice-Chairman*)
Dr. W. L. M. Perry, National Institute for Medical Research (Medical Research Council), London, United Kingdom
Dr. I. N. Orpwood Price, Director, Venereal Diseases Reference Laboratory (Public Health Laboratory Service), St. Peter's Hospital, London, United Kingdom
Professeur J. Tréfouël, Directeur de l'Institut Pasteur, Paris, France
Dr. M. V. Veldee, Medical Director, Hyland Laboratories, Los Angeles, Calif., USA

Secretary :

Dr. W. Aeg. Timmerman, Director, Division of Therapeutic Substances, WHO

[2] *Bull. World Hlth Org.* 1950, 3, 301

Standards and Reference Preparations under Study

The committee authorized the National Institute for Medical Research, London, and the Statens Seruminstitut, Copenhagen, to carry out the following work on substances within their respective fields :

Vitamin B_{12}. Determine the properties of the vitamin B_{12} preparation intended for use as a standard preparation.

Dihydrostreptomycin. Obtain a preparation of dihydrostreptomycin suitable for use as a reference and define its potency, either in units or in microgram-equivalents.

Aureomycin and terramycin. Establish standards for these two antibiotics.

Chloramphenicol. Establish a reference preparation for this substance. Although it is possible to characterize this antibiotic chemically and physically, biological assay is still used by certain workers ; consequently, a reference preparation is necessary.

Bacitracin. Establish an international reference preparation, since investigation does not seem to have reached a stage which would justify the establishment of an international standard.

Thyrotrophin, and the growth hormone of the anterior pituitary. Establish for each of these hormones a reference preparation which might later be adopted as an international standard.

Thrombin. Procure a preparation of thrombin and obtain the opinion of interested workers as regards its adoption as an international standard and the unitage to be assigned to it.

As regards fibrinogen and prothrombin, research did not appear sufficiently advanced for a decision to be taken.

Oxophenarsine and dimercaprol. Establish international standards for these two substances, which will be included in the *Pharmacopoea Internationalis.*

Dextro-tubocurarine. Establish an international standard chosen so that the unit of potency is the activity contained in 1 mg of the standard preparation.

Hyaluronidase. Request the opinion of interested workers on the British standard preparation of hyaluronidase and on its suitability as an international standard, and consult them regarding the unitage to be assigned to it.

Hyaluronidase is the generic name applied to the group of enzymes depolymerizing hyaluronic acid which occurs in the form of a highly polymerized polysaccharide in the mesenchyma and which opposes the diffusion of liquids injected into this tissue. Hyaluronidase facilitates

penetration of the liquid injected and extends its radius of action. This substance is employed to enhance the effect of local analgesics and to accelerate the absorption of substances injected subcutaneously. The product is now used clinically on a sufficiently large scale to make its standardization necessary.

Rh blood-grouping sera. Establish standards for anti-rh′ (anti-C), anti-Rh° (anti-D), and anti-rh″ (anti-E) blood-grouping sera of the blocking variety.

Streptococcus antitoxin. Establish an international standard for streptococcus antitoxin.

Rickettsial and enteric diagnostic antisera. Distribute these antisera, as soon as all sets are completed, to the laboratories selected for the collaborative testing.

Cardiolipin and lecithin. Establish international standards for the cardiolipin and purified lecithin used in the serodiagnosis of syphilis.[3]

Pyrogens. The committee was consulted by the Expert Committee on the Unification of Pharmacopoeias as regards the eventual establishment of a standard preparation of pyrogenic substances, since a test for pyrogens is to be given in volume II of the *Pharmacopoea Internationalis.* The committee felt that it was at present difficult to decide what type of substance should be used as a standard. It recommended, therefore, that different specimens of pyrogens from various countries should be collected so as to facilitate further research in this field.

Replacement of Standards

Digitalis

Analysis of the results of the assay of the third international digitalis standard, carried out in sixteen laboratories in eight countries, led to a definition of the international unit of digitalis (third standard) as being the activity contained in 76 mg of the standard preparation.[4]

Various other standards need to be replaced since the available stocks are almost exhausted. The substances involved are penicillin, insulin, and sulfarsphenamine. The results of the assay of histolyticus antitoxin carried out in several laboratories in order to establish the new standard will soon be available.

Diagnostic Rickettsial Suspensions

The Joint OIHP/WHO Study-Group on African Rickettsioses had recommended the preparation of standard suspensions of various rickettsiae

[3] An article on the preparation of these substances will appear in a forthcoming number of the *Bulletin of the World Health Organization.*

[4] *Bull. World Hlth Org.* 1950, **2**, 655 ; summarized in *Chron. World Hlth Org.* 1950, **4**, 347

to facilitate diagnosis of the rickettsioses. The committee noted this recommendation and expressed the opinion that the use of standard rickettsial antigens was to be encouraged. It considered that the grant of technical and financial aid, referred to in the report of the joint study-group,[5] would further the work on the distinction between the various types of rickettsiosis occurring in Africa.

Vaccines

Cholera vaccines

To establish the provisional reference preparation as an international reference preparation, a collaborative assay of freeze-dried cholera vaccines of unknown potency in terms of the provisional reference vaccine will be organized between several laboratories.

International preparations of cholera vibrios of the Ogawa and Inaba types in the dried state will be established for use in the preparation of diagnostic antisera in the rabbit.

Pertussis vaccine

A dried vaccine of proved protective value for man will be assayed in several laboratories with a view to establishing it as an international reference preparation of pertussis vaccine.

Smallpox vaccine

The committee felt that, in accordance with the resolution of the Third World Health Assembly, an investigation should be made of the value of dried smallpox vaccine. Technical directives in this connexion were formulated by the committee.

Toxoids

Diphtheria toxoid

Two provisional diphtheria toxoid reference preparations were established, one a plain toxoid and the other an aluminium-phosphate adsorbed toxoid. The dose-response curve of various toxoids will be investigated and interested workers consulted as regards the unitage of immunizing power to be assigned to the reference preparations.

BCG

Liquid or dried vaccine

In the present state of our knowledge, no general recommendation can be made concerning the preferential use of BCG in the liquid or dried form. Although the dried vaccine should have better keeping properties, the

[5] *World Hlth Org. techn. Rep. Ser* .1950, 23, 18

production of freeze-dried vaccine may be beyond the facilities of some laboratories capable of preparing a good liquid vaccine. The committee decided to investigate certain reports that liquid vaccines retain their properties much longer than was previously thought.

Centres for the testing and preparation of BCG vaccine

In response to the request of the United Nations International Children's Emergency Fund (UNICEF), the committee recommended that the BCG pilot-station in Paris and the WHO Tuberculosis Research Office, Copenhagen, be recognized as centres for the periodic testing of BCG vaccine.

Furthermore, it approved the reports on the laboratories for the preparation of BCG at Athens, Casablanca, Mexico City, Parkville, Saigon, Taipeh, and Tunis.

WHO CONGENITAL HEART DISEASE TEAMS

Because of the specific needs of certain geographical areas and the varying stages of medical development of Member States, WHO advisory and demonstration services cover a wide range of activities, both as to subjects and as to the degree of specialization within them. In underdeveloped areas, efforts have to be concentrated on introducing fundamental health procedures and techniques ; in more advanced countries, where such skills may be taken for granted, WHO has to provide services of a more specialized nature.

Among the projects specifically designed for the medically more advanced countries are the WHO congenital heart disease teams. These teams, which have to date visited Austria, Israel, Poland, Turkey, and Yugoslavia, are really thoracic surgery teams rather than groups dealing exclusively with congenital heart disease, though emphasis has been placed on modern diagnostic methods and surgical treatment of congenital malformations of the heart. The composition of the teams and their programmes have been adapted to the particular circumstances of the countries visited. Expert cardiologists have accompanied two of the teams : Dr. E. Mannheimer, of Stockholm, visited Austria and Yugoslavia ; Dr. A. T. Hansen, of Copenhagen, visited Israel and Turkey.

A number of prerequisites had to be met for the host countries to derive the full benefit of such short demonstration periods as those afforded by the WHO surgical teams. In none of the countries visited had any operations ever been performed for congenital heart disease, with one exception ; in all of them, cardiac surgery was successfully introduced by team visits of from two to four weeks. This obviously could be accomplished only

in countries where chest surgery had already been practised and where there were surgeons of sufficient experience to profit from the demonstrations. In some of the countries, surgeons had been doing experimental cardiac surgery on dogs and had practised some of the operations on cadavers ; they were therefore able to use the presence and assistance of the visiting team to start operating on living patients. Actually, the availability of adequately skilled surgeons in the recipient countries was the least difficult prerequisite to fulfil ; the need for fully trained anaesthesiologists and nurses often presented greater difficulties. Among other essential requirements were adequate standards in pre- and post-operative treatment, blood banks, laboratory facilities, etc. In all the countries visited by the WHO teams, conditions were only more or less favourable ; but in all of them they were satisfactory enough to ensure the success of the project.

During the summer of 1948, three thoracic surgeons—Professors C. Price-Thomas, of London, and Clarence Crafoord, of Stockholm, and Dr. H. Good, of Basel—together with their supporting staffs, visited Poland for approximately one month. When a WHO representative went to Poland one year later, Dr. Manteuffel, chief thoracic surgeon at the Hospital of the Transfiguration in Warsaw, could already demonstrate " blue babies " on whom he had performed successful operations.

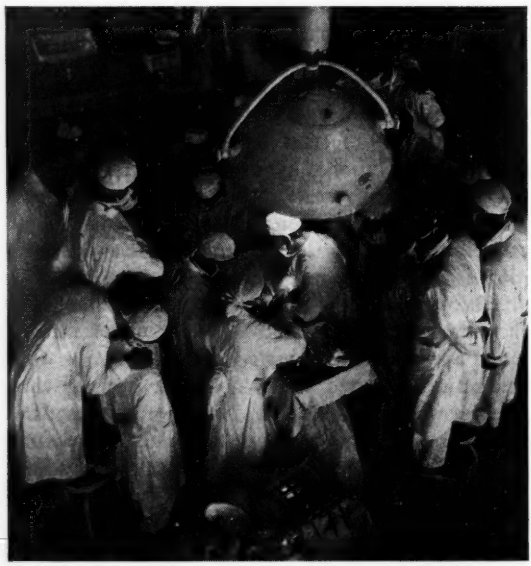
During the visit of Professor Crafoord's team to Vienna in the early summer of 1950, operations on the following were demonstrated : 1 case of patent ductus arteriosus, 2 cases of coarctation of the aorta, 5 cases of tetralogy of Fallot (Blalock-Taussig operation), 1 case of tetralogy of Fallot in which an end-to-end anastomosis between the subclavian and pulmonary arteries was performed, and 2 cases of atresia of the tricuspidal valve (Blalock-Taussig operation). All of these were performed at the Second Surgical Clinic of Professor W. Denk, who assisted Professor Crafoord and later, towards the end of the project, performed the operations himself, with Professor Crafoord assisting. In his report on the visit of the team, Professor Denk said that, thanks to the work of the team and to the instruments and apparatus supplied, surgical treatment of congenital heart disease could now be carried out in Austria ; the team had thereby " provided most important assistance to Austrian medicine and also a powerful stimulus for continued work in this important and interesting field ". In a later report, Professor Denk added : " How important it was that the team came to Vienna and that the possibility of performing these operations has been created can be judged by the fact that not only are 40 out of the 80 now assembled cases of congenital heart disease suitable for and in need of surgical treatment, but also that from all over Austria new inquiries and requests for admission are being received at the clinic daily ".

The situation was somewhat similar in Yugoslavia, where the government assembled a considerable number of suitable patients, from all over

the country, in Zagreb, where surgeons from the whole country came to witness the operations and to attend lectures and discussions. Since the team left, reports have been received from Yugoslavia on the first few successful operations on "blue babies" performed by Yugoslav surgeons.

Last November a Danish team, under the leadership of Professor E. Husfeld, of Copenhagen, visited the universities of Istanbul and Ankara and then proceeded to Israel. In Turkey the team worked in close

FIG. 4. CONGENITAL HEART DISEASE TEAMS



Thoracic surgery team, under Professor Husfeld, at work in an operating-theatre at Istanbul

co-operation with the WHO Tuberculosis Demonstration Centre in Istanbul, and considerable attention was given to resections, pneumonectomies, etc.—operations which had not yet become routine with thoracic surgeons in that country. The following were performed during the team's one-month visit in Turkey : 4 pericardiectomies for constrictive pericarditis, 4 Blalock operations and 1 Barrett operation for tetralogy of Fallot, 2 valvulotomies for mitral stenosis, 1 exploratory thoracotomy for cancer, 2 lobectomies for hydatid cysts, 4 lobectomies for tuberculosis and bronchiectasis, 5 pneumonectomies for tuberculosis, bronchiectasis, and cancer, 2 decortications for chronic empyema, 1 Monaldi operation for

tuberculous cavity, 1 thoracoplasty (Overholt), 2 oesophagoplasties for caustic stricture, 1 gastro-oesophageal resection for caustic stricture, 1 closure of broncho-oesophageal fistula, 1 extraction of foreign body from the oesophagus, and 2 diaphragmatic herniotomies. In addition to performing these operations, the team examined a considerable number of patients, gave lectures on the surgical treatment of pulmonary tuberculosis, anaesthesia for chest surgery, and modern diagnostic methods in congenital heart disease, held informal discussion meetings, and demonstrated bronchoscopy, oesophagoscopy, cardiac catheterization, and other techniques.

During the team's two weeks' visit to Israel, 13 surgical operations were performed, including lobectomies, Blalock and Barrett procedures for tetralogy of Fallot, closures of patent ductus arteriosus, a valvulotomy for mitral stenosis, and a not very commonly performed valvulotomy for pulmonary stenosis.

FIRST SEMINAR FOR EUROPEAN SANITARY ENGINEERS

The first seminar for European sanitary engineers, held at The Hague from 27 November to 2 December 1950, was sponsored jointly by the Government of the Netherlands, the International Health Division of the Rockefeller Foundation, and the World Health Organization. Sixteen European nations sent as delegates to the meeting their senior sanitary engineers, or, in lieu of such personnel, those most directly concerned with environmental sanitation. There were 40 representatives of governments and 14 representatives of the sponsoring agencies, making a total of 54 participants.

The primary objectives of the conference were :

(1) To disseminate knowledge of the status and needs of sanitary engineering in the various countries ;

(2) To stimulate and co-ordinate European research in environmental sanitation ;

(3) To bring about closer relationships between sanitary engineers in the countries of Europe.

The programme was designed to produce an informal atmosphere and to promote free discussion, minor emphasis being given to prepared papers. Papers and discussions covered a large number of the subjects included in environmental sanitation. Intensive and prolonged discussions on technical points were purposely avoided at this first seminar in an attempt to obtain

a general picture of the whole field which might serve as a point of departure in drawing up programmes for future seminars. The objective of having a seminar rather than a congress was satisfactorily achieved.

The seminar reached the following conclusions :

(*a*) The utilization of modern public-health techniques provides an ever-increasing opportunity for raising living standards and improving economic conditions, in Europe and throughout the world. Modern public-health practice requires the co-operation of various professions and the utilization of a vast and complex store of scientific knowledge.

(*b*) Interchange of knowledge between European countries and collaboration between sanitary engineers and medical hygienists are essential, and WHO can play an important role in their promotion.

(*c*) It was recognized that in all countries the improvement of environmental conditions is essential to the well-being and productivity of mankind. The installation of necessary sanitary works has been retarded by financial difficulties. There is need to develop an awareness of the economic and social value of sanitary works and of the necessity for providing adequate financial support.

(*d*) Because of the lack of basic information on many of the subjects which were covered during the seminar, and because of the varying needs in different countries, fundamental research and practical investigations are urgently needed in order to provide practical and economic solutions to many sanitary problems. In order to avoid duplication and to increase the productivity of individual research projects, it is considered advisable that a central agency be designated to co-ordinate and correlate this work, with particular emphasis on methods, standards, and measures. It is hoped that such co-ordination will facilitate the formulation of international standards in environmental sanitation. One type of problem which might be studied by such a committee is the total management of water economy. Thus, through co-ordinated activity, various phases of the problem, such as demineralization of brackish water, pollution of natural ground-water, and re-use of liquid wastes, could be integrated into an overall programme. The facilities of WHO appear to be suited to this co-ordination and correlation, and it is hoped that the Organization will give consideration to the possibility of undertaking such a function.

(*e*) Control of the environment is now recognized as an important function in public-health practice, and engineering techniques and the use of engineering personnel are becoming increasingly important. It therefore seems desirable that governments should have, in their public-health organizations, adequate provision for the utilization of engineering sciences. Such engineering services should be staffed with adequately trained professional personnel ; and, in addition, provision should be made, either on a national or a regional basis, for the education of such personnel. (The

ultimate objective, with regard to education, should be the provision of full postgraduate training of men adequately grounded in the basic engineering sciences. Until this objective can be attained, it is recognized that undergraduate training will be necessary.)

(*f*) There is a real need for the unhampered distribution of technical literature on public-health subjects, and every encouragement should be given to the several agencies concerned with facilitating this work.

(*g*) A committee should be appointed to give further consideration to ways and means of attaining the objectives outlined above.

(*h*) Seminars such as the present one should be repeated, and WHO should immediately study the possibility of more systematic contact among sanitary-engineering experts throughout Europe.

The greatest benefits of this meeting are believed to be the intangible and invisible ones. For the first time, the leading sanitary engineers of all the European countries which are now Member States of WHO were brought together. There was complete compatibility, and friendships were formed which will continue through the years. Although some delegates arrived feeling sceptical about the benefits of the meeting, all left it with enthusiastic praise for what it had accomplished and with a demand that a similar meeting be held in 1951.

AN IMPORTANT STUDY ON MATERNAL CARE AND MENTAL HEALTH

The Social Commission of the United Nations, at its third session (April 1948), resolved to undertake a study of the needs of homeless children, " homeless " in this instance referring to those separated from their families in their native countries, thus excluding refugee children. WHO offered to contribute a study on the mental health aspects of the problem of homeless children and, this offer having been accepted, appointed Dr. John Bowlby, Director of the Child Guidance Department of the Tavistock Clinic, London, to make a survey which took him to France, the Netherlands, Sweden, Switzerland, the United Kingdom, and the USA. The results of this investigation, and of extensive literature searches, have been summarized in a report, " Maternal care and mental health ", which is now published as No. 2 of the *World Health Organization : Monograph Series.*[1]

Dr. Bowlby's report is much wider in scope than its title might suggest, although Part I is chiefly concerned with the adverse effects of deprivation

[1] Available also in a French edition.

of maternal care and Part II with the prevention of such deprivation. Under the latter heading, however, Dr. Bowlby deals with the psychological aspects of a number of sociological problems—the causes and prevention of failure of the family, illegitimacy, adoption, foster and boarding homes, institutions for children, the care of maladjusted and sick children, and the administration of child-care services.

Dr. Bowlby emphasizes the importance to the healthy psychological development of children of a normal, stable family life during the early, formative years. An infant needs a warm, continuous relationship with his mother, or permanent mother-substitute. Deprived of this relationship, he more often than not suffers serious retardation in development, physically and socially as well as mentally. Infants confined to institutions for a considerable length of time usually present a picture of pallor, emaciation, and unresponsiveness. The emotional trauma caused by deprivation of maternal care in early life often results in adult maladjustments ; prolonged deprivation may foster the development of an affectionless, psychopathic character given to delinquent behaviour. A love-starved infant may become an adult incapable of making satisfactory human relationships. It is easier to prevent deprivation of maternal care than to eradicate its ill effects.

Child-care studies indicate that even a bad home usually provides a healthier emotional environment than does a good institution. It therefore becomes the duty of governments and social agencies to try to keep the family intact in so far as possible, and to strengthen family relationships rather than to separate children from their parents. This may necessitate supplying financial assistance, medical or psychological care for parents or children, or even, in some cases, domestic help.

If a situation arises which absolutely requires removal of a child from his home, then the next step is to try to provide the most satisfactory substitute. Sometimes relatives may prove to be the answer ; failing this, a suitable foster-home should be found. The best foster-home is one in which the proxy parents have a real understanding of children and, possibly, children of their own.

When institutional care must be resorted to, every effort should be made to create a homelike atmosphere in the institution. The cottage type of arrangement, in which small groups of children are entrusted to the care of specially trained house-parents, is most successful in achieving this goal.

In any solution to the problem of a " home " for homeless children, the primary requisite is provision of a satisfactory mother-substitute with whom a compensatory relationship can be developed. An arrangement which ignores the essential nature of this relationship is, from a psychological standpoint, doomed to failure. In every case, the individual child and his needs must be studied before any major decisions are reached. Generally, outpatient methods of observation are best for such study.

In discussing the care of sick children, Dr. Bowlby calls attention to the possible emotional and psychological maladjustments which are apt to arise from lengthy hospitalization. It has been shown that children respond to treatment much better if their mothers have a part in their care. Whenever possible, the sick child should be kept at home. If hospitalization cannot be avoided, steps should be taken to enable the mother to spend as much time with the child as is practicable, even if this entails providing domestic aid for the household and admitting the mother to the hospital along with the child.

In addition to discussing these various aspects of maternal deprivation and its prevention, Dr. Bowlby points to the need for research on the problem of homeless children, suggesting as subjects (1) the forces affecting family life which make its functioning inadequate ; (2) the relative contribution of each of these forces in depriving children of maternal care ; and (3) the best way to care for children outside their homes when this course of action becomes necessary.

Homeless children represent a real public-health problem, as Dr. Bowlby makes clear in his conclusion :

" The proper care of children deprived of a normal home life can now be seen to be not merely an act of common humanity, but to be essential for the mental and social welfare of a community. For, when their care is neglected . . . they grow up to reproduce themselves. Deprived children, whether in their own homes or out of them, are a source of social infection as real and serious as are carriers of diphtheria and typhoid. And just as preventive measures have reduced these diseases to negligible proportions, so can determined action greatly reduce the number of deprived children in our midst and the growth of adults liable to produce more of them. . . . To those charged with preventive action the present position may be likened to that facing their predecessors responsible for public health a century ago. Theirs was a great opportunity for ridding their countries of dirt-borne diseases ; some took it, others remained hypercritical of the evidence and inert. . . . Let it be hoped, then, that all over the world men and women in public life will recognize the relation of mental health to maternal care, and will seize their opportunities for promoting courageous and far-reaching reforms."

INSECTICIDES AND PUBLIC HEALTH

Several articles on the control of insect vectors of disease and their destruction by means of residual insecticides have recently appeared in the *Bulletin of the World Health Organization.*

Malaria control by means of residual insecticides, undertaken in all parts of the world, has given impressive results. In countries such as Argentina, Greece, and Italy, where malaria was a traditional scourge, it has now ceased to be a public-health problem. The regression of endemicity in all countries where the campaign has been carried on and in which

millions of people have been protected has brought about a reduction in malaria mortality- and morbidity-rates, a general rise in public-health standards, increased manpower efficiency, and a higher agricultural and industrial output. This is proved by the data supplied to WHO concerning 35 countries of Africa, America, Asia, and Europe, several of which have requested WHO's technical assistance for the implementation of their control programmes. These data were analysed and commented upon by Dr. E. J. Pampana, Chief, WHO Malaria Section, in an article written by him at the suggestion of members of the Executive Board on large-scale malaria-control campaigns using residual insecticides.[1] The following is a summary of the most important points :

In the Union of South Africa antilarval measures and residual insecticide spraying were applied to 108,000 km² of the malarious area of 150,000 km²; in over 45,000 km² the technique adopted was that of DDT indoor residual spraying only. After the application of all these measures it was shown that blackwater fever had disappeared and that there was an impressive regression in the spleen and parasite indices. In Southern Rhodesia similar results have been obtained.

In Madagascar, the campaign began in September 1949. A year later more than 1 million inhabitants had been protected.

In Mauritius, where malaria is very widespread and takes a serious form, the campaign—which aimed at eradication of the *Anopheles gambiae* and *A. funestus* vector species—began in January 1949. By June 1949, *A. funestus* seemed to have disappeared from most of the treated territory. There was a significant reduction in the general and infant mortality figures for 1949 compared with those of previous years.

In Argentina, eradication campaigns began in 1947. During the first six months of 1949 some 2,800 cases of malaria were notified as against 300,000 annually before the commencement of the campaign. The author cites Alvarado et al., according to whom " endemic malaria has ceased to be a health and social problem in Argentina ".

In Bolivia nearly half the population lives in malarious territory. In 1946, in the sectors under the control of the Special Prophylaxis Service, malaria morbidity was 21% and mortality 2%.

In Brazil malaria is encountered almost everywhere and it is perhaps in this country that the most extensive control programme has been applied. Although the residual spraying is not effective against certain vector species which are not particularly domestic, it is extremely efficacious in dealing with the chief vector : *A. darlingi*. A vast programme of control by means of DDT-spraying was undertaken in 1947. The total number of cases of malaria notified in a certain number of localities subjected to treatment since 1947 or 1948 fell from 18,297 in 1945 to 976 in 1949 ; in several

[1] *Bull. World Hlth Org.* 1951, 3, 557 (Article in French with summary in English and French)

localities the parasite index fell to zero. In 1950, about 2,650,000 houses were treated and about 12,750,000 persons protected.

In Ecuador a nation-wide scheme of malaria control by residual spraying was started in 1949, and in March 1950 already some 800,000 inhabitants were protected.

In the USA, the action of DDT has accelerated a natural decline in malaria infection which has been apparent since 1935. The campaign has been limited to 13 States considered as malarious. In 1945, the Communicable Disease Center of the US Public Health Service began to study the possibility of reducing transmission of the disease so that malaria should cease to exist as a public-health problem, and it may be said that, to all intents and purposes, this aim was achieved by 1949. The malaria mortality-rate per 100,000 inhabitants over the whole of the 13 States in question declined from 12.6 in 1933 to 0.4 in 1948.

In British Guiana, the campaign began in January 1947. By the following year more than 90% of the population had been protected. In one village, for example, the spleen index fell from 71.6% in 1945 to 4% in 1948. In 1947, the total cost of the DDT-spraying and the hospitalization of patients was less than the costs of hospitalization alone in 1945, not counting the loss of wages due to the disease. In addition, complete prophylaxis against yellow fever was effected and transmission of filariasis considerably reduced.

Nearly all the States of Mexico are affected by malaria. The annual number of cases was estimated in 1946 as 2 millions, and the malaria mortality-rate was 110.3 per 100,000 inhabitants. In 1948 DDT was applied in 13 States. The necessary information for the evaluation of the results of the campaign is not yet available, but a considerable reduction in the number of vector anophelines has been observed ; in some regions they have completely disappeared.

In Peru, 3 million of the total of some 8 million inhabitants live in malarious zones. The cost of the campaign, if extended to the whole of the population of these zones, would represent only one-fifth of the annual loss caused by malaria. As a result of the campaign undertaken in 1946, the parasite index in the Lima zone, for example, fell from 13.4% (average for the years 1942-6) to 0.06% in 1949.

In Venezuela the national campaign is to cover 600,000 km². In 1948, about 863,000 persons were protected. In one of the localities of a hyperendemic region the spleen index, which was 98.6% in 1945, fell to 15.5% in 1949.

In Asia, Ceylon was the first country to undertake control by DDT-spraying on a national level. Most of the 7,300,000 inhabitants live in the malarious zone which covers two-thirds of the island. As a result of the campaign, infant mortality over the country as a whole in 1949 was only 62% of what it was in 1946, the greatest decrease being shown in the most malarious regions.

In India, Bombay State furnishes an excellent example of treatment of rural zones. At the end of 1950, the campaign covered seven districts and protected about 5½ million inhabitants. It is estimated that in the protected region the annual number of cases of malaria has decreased by about 300,000. In addition, plague has disappeared and, in the centres where stables have been treated, mortality from diarrhoea or dysentery has diminished. The report on the 1947-8 campaign shows that in a treated village in Delhi Province the infant parasite-rate was nil as against 20% in a non-treated control village ; the number of cases of malaria was 16 times greater in the non-treated than in the treated village.

Only four European countries are dealt with : Greece, Italy, Portugal, and Yugoslavia, whose campaigns are based on the practice of residual spraying. In Greece, which is considered as the most malarious country in Europe, morbidity was approximately 1 million to 2 million cases per year between 1930 and 1940. Malaria took second place among the causes of infant mortality. After an intensive campaign for four years, malaria " has ceased to constitute a serious public-health problem ". It was estimated that between 1946 and 1949, 19,000 human lives and 80 million working days were saved. Moreover, the campaign also brought about a regression in leishmaniasis, the disappearance of pappataci fever, and the suppression of sandflies in certain localities. The protection of peasants from malaria has made it possible to extend rice cultivation ; the production of certain farms appears to have increased by about 40%.

One of the first experiments in malaria control by DDT residual spraying was carried out in Italy in 1944. In 1942 the morbidity-rate was 3,629 per million inhabitants, the mortality-rate 23.77 per million and the case fatality-rate 0.6%. In 1949 the morbidity-rate had fallen to 422 per million and the other two rates had reached zero.

In Portugal, 50,000 to 70,000 persons per year were affected by malaria before the campaign. DDT and benzene hexachloride have been used since 1948. The results of the campaign are not yet known.

In Yugoslavia the national control plan was commenced in 1947 and about 5 million inhabitants of the malarious region are now protected. The necessary labour is supplied gratis by certain popular organizations. As a result of spraying, malaria morbidity has considerably decreased ; there is no longer an autumnal peak corresponding to new infections.

Malaria control is also the subject of a study of regional interest entitled " Malaria control using indoor residual sprays in the Eastern Province of Afghanistan " [2] by T. Ramachandra Rao, leader of the WHO Malaria Control Demonstration Team to Afghanistan. The author describes a short malaria survey and a small-scale demonstration project for malaria control which were carried out in Laghman District from July to October 1949. A marked decrease in morbidity, as shown in the spleen

[2] *Bull. World Hlth Org.* 1951, 3, 639 (Article in English with summary in English and French)

and parasite indices, was observed after DDT spraying. The formulations used were DDT-Aromex-soap emulsion and water wettable powders.

The flight range of gravid and newly emerged anopheles is the subject of an article by Antonio Ejercito and Cornelio M. Urbino of the Section of Malaria Control, Division of Laboratories, Department of Health, Manila, Philippines.[3] During an experiment carried out in 1937 at Tungkong Manga, Philippines, the authors demonstrated, by the recapture of marked mosquitos (0.14% of released insects were recaptured) that the flight range varied between 640 m and 2,016 m. In the majority of cases the flight only deviated very slightly from the direction of the wind.

It is known that a secondary result of the action of residual insecticides on anopheles has been the destruction of other insect and acarian vectors of disease. There is already extensive literature on the subject and the various published works have been reviewed by Dr. S. W. Simmons, Scientist Director, Chief, Technical Development Services, Communicable Disease Center, US Public Health Service, Savannah, Ga., USA, and member of the Expert Committee on Insecticides of the World Health Organization, and Dr. W. M. Upholt, Senior Scientist, Assistant Chief, Technical Development Services, Communicable Disease Center, US Public Health Service, Savannah, Ga., USA, in an article entitled " Disease control with insecticides ".[4] After giving the results obtained in the campaign against malaria, the authors describe the action of the insecticides on vectors of various other diseases. The following is a summary of this part of their study :

As regards urban yellow-fever and dengue fever, although valid epidemiological evidence is not available, there should be little doubt as to the effectiveness of insecticides in the control of these diseases. In the case of epidemic encephalitis, an additional factor, that of unknown vectors, has established this disease as unique, in that failure to control it with specific insecticides may be used as evidence of the existence of unknown vectors. Filariasis is a disease which should certainly be susceptible to control by insecticides and, since it is of such widespread importance in tropical countries, it may be expected that more evidence will be available in the future.

Of louse- and flea-borne diseases, there is abundant evidence that typhus and plague have been greatly reduced by the use of DDT. DDT was first introduced in the control of epidemic typhus during the second World War. However, other methods of control, including immunization, have been so widely used that an objective evaluation of the importance of insecticides is difficult to obtain.

In the case of those diseases believed to be transmitted by filth flies, valid epidemiological evidence is not great. It is apparent that fly control

[3] *Bull. World Hlth Org.* 1951, 3, 663 (Article in English with summary in English and French)
[4] *Bull. World Hlth Org.* 1951, 3, 535 (Article in English with summary in English and French)

cannot be expected to give more than partial control over enteric diseases such as diarrhoea and dysentery. Some epidemiological evidence exists as to effectiveness of insecticides in the control of sandfly fever, leishmaniasis, and bartonellosis. In the case of onchocerciasis, although insecticides have resulted in the control of the vector, no epidemiological evidence has been published on the effect on the incidence of the disease, probably as a result of the very long incubation period.

African sleeping-sickness appears to be the one insect-borne disease against which insecticides have so far been of little value. Chagas' disease may be in this category but there is reason to believe that it is now succumbing to insecticidal measures. Scrub typhus is apparently quite adequately controlled through the use of repellents, but there seems to be little epidemiological evidence available in the literature.

In Egypt, housefly breeding has become a public-health menace. Interest in the problem was stimulated during the 1947 cholera epidemic, during which a campaign for the destruction of houseflies was organized. In an article entitled "Preliminary studies on houseflies in Egypt",[5] Dr. S. Madwar, Director-General, Endemic Diseases Department, Ministry of Public Health, Cairo, Egypt, and Dr. A. R. Zahar, Head of Fly Control Branch, Insect Eradication Section, Ministry of Public Health, Cairo, Egypt, describe the various methods adopted for estimating the density of housefly populations ("fly grids", tanglefoot paper, and bait-traps). The capture of the insects made it possible to establish that there are seasonal variations—an increase in the number of insects in April, a decrease from the end of May to August, and an increase again during the autumn. Control is difficult owing to the poor sanitary conditions which encourage the formation of breeding-places. The results obtained with residual insecticides vary. They are often unsatisfactory where the flies are numerous and where certain strains have possibly become DDT-resistant, and, on the other hand, remarkably good elsewhere. Further investigations are proceeding.

[5] *Bull. World Hlth Org.* 1951, 3, 621 (Article in English with summary in English and French)

Notes and News

Health Demonstration Area to be Established in El Salvador

The first health demonstration area to be established in the Americas under the United Nations Technical Assistance Programme will be located in El Salvador. This announcement was recently made by Dr. F. L. Soper, Director of the WHO Regional Office for the Americas, who signed an agreement with the Government of El Salvador

in accordance with which the United Nations and the specialized agencies will provide technical assistance for the project. WHO's contribution for the first year will amount to approximately $150,000, which will be expended on equipment, supplies, and training fellowships. The Government of El Salvador, through its Ministry of Public Health and Assistance, will provide approximately $200,000 during the same period for health personnel, buildings, and supplies. The Government has already trained more than 25 people to work in different phases of the project.

The demonstration area, which will be in the central part of the Republic, just north of the city of San Salvador, has a population of 100,000. It was selected as a typical, rural area representative of large regions in Latin America. Headquarters will be the town of Quezaltepeque (population 16,000), which has contributed land and buildings for the demonstration project. Eleven other towns have offered facilities for clinics, and several have offered funds for sanitation improvements. These contributions supplement those of the Government itself and are an expression of the spirit of co-operation in which the project is being undertaken.

All aspects of public health will be included in the demonstration project—environmental sanitation ; maternal and child health ; nutrition ; control of malaria, tuberculosis, and other communicable diseases ; dental hygiene ; laboratory services ; health education ; and public-health training. Assistance in drawing up the plans was given by Dr. M. I. Roemer, Assistant Professor of Public Health at Yale University, who was loaned to WHO to make a ten-week survey of the Republic's needs and to give advice on how to meet them. Plans for other programmes to be integrated with the health demonstration project—e.g., in agriculture, labour relations, education, and social welfare—are in progress.

Malaria Course in Lisbon

A malaria training-course of two-and-a-half months' duration, commencing 4 June 1951, will be held at the Malaria Institute, Aguas de Moura, and at the Institute of Tropical Medicine, Lisbon, under the auspices of WHO and the Portuguese Ministry of the Interior, Directorate General of Health. Training will consist of laboratory courses as well as field trips. Instruction will be given in French. Approximately ten Fellows will be accepted. Applications, sponsored as usual by national health-administrations and recommended by regional offices, should be sent as soon as possible to WHO Headquarters at Geneva.

Malaria Control in Indonesia

WHO has agreed to provide international personnel to aid in an antimalaria campaign in Tjilatjap, on the south coast of Java. A training centre for local malaria workers will also be included in the project. It is expected that supplies and equipment will be provided by the Economic Co-operation Administration (ECA).

Antimalaria Campaign in Thailand

A UNICEF/WHO malaria-control team operating in North Thailand is training 14 Thai workers for field and laboratory service in projects to be launched in other parts of the country, with equipment and supplies to be provided by the Economic Co-operation Administration (ECA). DDT spraying in North Thailand has had a welcome side-effect : it has rid houses of bedbugs, so that villagers now claim to enjoy sound sleep for the first time in their lives. In unsprayed houses, an average of four bedbugs per square foot of the floor under the bed has been recorded.

Saudi Arabia to Receive WHO Assistance

Following a visit to Saudi Arabia by Dr. W. Omar, head of the Epidemiology Section of the WHO Regional Office for the Eastern Mediterranean, plans are being drawn up for assistance to this country in a number of health projects and programmes :

1. Building and equipping a new quarantine station at the port of Jedda, through which about 70,000 Moslem pilgrims pass every year. The Saudi Arabian Government is to erect the building, and WHO is to contribute laboratory equipment and the services of two medical experts, under provisions of the United Nations Technical Assistance Programme.

2. A fellowship programme which will include, in addition to two postgraduate grants for studies in tuberculosis and in bacteriology, awards for basic medical education, in an effort to try to augment the country's very limited number of doctors.

3. Aid in environmental sanitation improvements, WHO to supply the services of a sanitary engineer.

4. A malaria-control project, under the Technical Assistance Programme.

5. Expert advice concerning public-health administration, maternal and child health, and venereal diseases.

6. Expert assistance in a mass BCG-vaccination programme against tuberculosis.

Meeting on Draft International Sanitary Regulations

The Special Committee for considering the Draft International Sanitary Regulations will meet on 9 April 1951 at the Palais des Nations, Geneva. This committee, the establishment of which was approved by the Third World Health Assembly,[1] is being convened to give Member States an opportunity to discuss the various regulations before a final draft is submitted to the Fourth Health Assembly for approval.

World Health Day

Suggestions and background material for the annual celebration of World Health Day, on 7 April (date of the entry into force of the WHO Constitution), have been forwarded to Member Governments. The theme selected for this year is " Health for Your Child and the World's Children ", the aim being to promote interest particularly in services concerned with maternal and child health.

New Ratifications of Constitution

Laos, Cambodia, Viet-Nam, the Republic of the United States of Indonesia, and Panama (in order of date of ratification) have been added to the list of countries which have accepted the WHO Constitution.[2] This brings the total number of ratifications to 75 as of 1 March 1951.

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[1] *Chron. World Hlth Org.* 1950, 4, 227

[2] *Chron. World Hlth Org.* 1949, 3, 298 ; 1950, 4, 32, 194